STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 120292-001**

Health Alliance Plan of Michigan
Respondent

Issued and entered
this 28th day of September 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On March 28, 2011 XXXXX, on behalf of his minor[1] son XXXXX (Petitioner), filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

The Commissioner immediately notified Health Alliance Plan of Michigan (HAP) of the request for review and requested the information it used to make its adverse determination. The Commissioner received HAP's response on March 31, 2011. On April 4, 2011, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

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1 The Petitioner was born July XXx, 1997.

II. FACTUAL BACKGROUND

The Petitioner's health care benefits are defined in the HAP subscriber contract (the contract).

The Petitioner was diagnosed with autism and apraxia. On February 22, 2010, he began receiving speech and language therapy from XXXXX & Associates (XXXXX). XXXXX is a not an affiliated provider with HAP, i.e., it has not contracted with HAP to provide services to HAP members.

The Petitioner's parents asked HAP to reimburse them for the therapy the Petitioner had received and to authorize further treatment with XXXXX. When HAP denied the request, the Petitioner appealed that determination through HAP's internal grievance process. HAP affirmed its decision in its final adverse determination dated January 26, 2011.

III. ISSUE

Did HAP properly deny coverage for the Petitioner's speech and language therapy?

IV. ANALYSIS

Respondent's Argument

In its final adverse determination, HAP explained its denial of the speech and language therapy:

> . . . [T]he [grievance] committee was unable to provide an individual exception to provide you with reimbursement and continued treatment for the speech and language services your son received through XXXXX & Associates because services provided by non-affiliated providers are contractually excluded under the terms and conditions of your HMO Subscriber Contract as referenced in **Section 5 – Exclusions and Limitations, 5.2, Other Exclusions, (a)**. Additionally, the services provided through XXXXX & Associates are not covered benefits for their listed diagnosis.
>
> Additionally, the committee was unable to approve your request for your son to obtain speech and language therapy services through a HAP Affiliated Provider. . . . During the committee hearing, you stated that your son has been diagnosed with Apraxia and Autism. HAP's coverage criteria specifically states that speech and language therapies, for conditions, such as Apraxia, fall under the responsibilities of a Member's school district. Diagnosis, such as Autism,

> involves competencies for the treatment of communication disabilities that are not restorative in nature and therefore, are contractually excluded under your HMO Subscriber Contract with HAP. . . .

HAP acknowledged that it paid in error some claims from January and February 2010 for services performed by an affiliated provider. It also acknowledged it paid in error claims from for treatment from XXXXX but would not seek to recover those payments from the Petitioner's parents.

HAP contends that on January 26, 2010, it advised the Petitioner's mother of the need to use an affiliated provider but that the Petitioner's family elected to proceed with therapy from XXXXX with the knowledge that the services would not be covered.

Petitioner's Argument

The Petitioner's parents state that HAP covered the speech and language therapy their son received from XXXXX's Hospital, an affiliated provider. The Petitioner's father also states that HAP initially covered therapy at XXXXX. He believes that HAP should cover the therapy at XXXXX because the Petitioner is receiving the same type of speech and language therapy that was covered by HAP at XXXXX's Hospital, an affiliated provider.

Commissioner's Review

The contract describes the speech therapy benefit in "Section 4 – Services and Benefits" (p. 10):

> c. **Speech Therapy**
>
> 1) The therapy must be related to an organic medical condition (i.e., attributable to a physiological cause) or an immediate postoperative or convalescent state and be restorative in nature.
>
> 2) Short-term speech therapy services, either in the home or outpatient clinical setting, are covered when treatment begins following illness or injury.
>
> The number of visits for Medically Necessary speech therapy is a combined annual visit limit of 60 visits for physical therapy, speech therapy and occupational therapy.

The speech therapy benefit is intended to be restorative in nature and to treat organic medical conditions in the short term. HAP's policy on speech and language therapy further explains the limitations on the benefit:

COVERAGE CRITERIA:

1. Outpatient speech and language therapy is covered for HAP/AHL Members when all of the following criteria are met:

* * *

   d. The therapy must be related to an organic medical condition (i.e., attributable to a physiological cause) or an Immediate postoperative or convalescent state

   e. The therapy must be restorative in nature . . .

* * *

EXCLUSIONS:

1. The following services are excluded under the Member's HAP/AHL Subscriber Contract and would not be covered:

   a. Speech therapy for a condition which falls under the responsibilities of a Member's school district or other public agency, including but not limited to:

* * *

      vi. Natural dysfluency or developmental articulation errors (e.g., apraxia or dyspraxia)

* * *

2. The following list includes, but is not limited to, those illnesses, conditions and diagnoses that involve competencies for the treatment of communication disabilities that are not restorative in nature and for which Speech and Language Therapy is NOT a covered benefit of HAP:

* * *

   a. Autism

The Petitioner has been diagnosed with autism and apraxia. While there seems to be no dispute that speech and language therapy is medically necessary for the Petitioner, treatment for those conditions is not included in HAP's speech therapy benefit.

HAP was also correct in denying coverage for the services the Petitioner had at XXXXX. The contract (p. 17) excludes coverage for services provided by non-affiliated providers:

5.2 Other Exclusions:

   a. Services provided by a non-Affiliated Provider, except for an Emergency or Urgent Care or when specifically approved in advance by HAP or its designee.

HAP is a health maintenance organization (HMO). A fundamental feature of an HMO is the delivery of health care within a network of providers. The contract establishes that members must receive medical care from network providers unless care from a non-affiliated provider is approved in advance. There was nothing in the record to show that HAP approved services from XXXXX in advance.

The Commissioner concludes that the Petitioner's speech therapy is not a benefit under the contract and finds that HAP's denial of coverage for the Petitioner's speech and language therapy was in accordance with the terms of the contract.

V. ORDER

The Commissioner upholds Health Alliance Plan of Michigan's January 26, 2011, final adverse determination. HAP is not required to cover speech and language therapy services for the Petitioner.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.